Agency for Healthcare Research and Quality
Advancing Excellence in Health Care

NATIONAL QUALITY MEASURES CLEARINGHOUSE

General

Title

Follow-up after hospitalization for mental illness: percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days of discharge.

Source(s)

National Committee for Quality Assurance (NCQA). HEDIS 2016: Healthcare Effectiveness Data and Information Set. Vol. 1, narrative. Washington (DC): National Committee for Quality Assurance (NCQA); 2015. various p.

National Committee for Quality Assurance (NCQA). HEDIS 2016: Healthcare Effectiveness Data and Information Set. Vol. 2, technical specifications for health plans. Washington (DC): National Committee for Quality Assurance (NCQA); 2015. various p.

Measure Domain

Primary Measure Domain

Clinical Quality Measures: Process

Secondary Measure Domain

Does not apply to this measure

Brief Abstract

Description

This measure is used to assess the percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days of discharge.

See the related National Quality Measures Clearinghouse (NQMC) summary of the National Committee for Quality Assurance (NCQA) measure Follow-up after hospitalization for mental illness: percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental

illness diagnoses and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 30 days of discharge.

Rationale

It is important to provide regular follow-up therapy to patients after they have been hospitalized for mental illness. An outpatient visit with a mental health practitioner after discharge is recommended to make sure that the patient's transition to the home or work environment is supported and that gains made during hospitalization are not lost. It also helps health care providers detect early post-hospitalization reactions or medication problems and provide continuing care. According to a guideline developed by the American Academy of Child and Adolescent Psychiatry (AACAP) and the American Psychiatric Association (APA) (1997), there is a need for regular and timely assessments and documentation of the patient's response to all treatments.

The specifications for this measure are consistent with guidelines of the National Institute of Mental Health and the Centers for Mental Health Services.

Evidence for Rationale

American Academy of Child and Adolescent Psychiatry, American Psychiatric Association. Criteria for short-term treatment of acute psychiatric illness. 1997.

National Committee for Quality Assurance (NCQA). HEDIS 2016: Healthcare Effectiveness Data and Information Set. Vol. 1, narrative. Washington (DC): National Committee for Quality Assurance (NCQA); 2015. various p.

Primary Health Components

Mental health disorder; follow-up care

Denominator Description

Discharges for members age 6 years and older as of the date of discharge who were hospitalized for treatment of selected mental illness diagnoses and who were discharged from an acute inpatient setting with a principal diagnosis of mental illness on or between January 1 and December 1 of the measurement year (see the related "Denominator Inclusions/Exclusions" field).

Numerator Description

An outpatient visit, intensive outpatient visit, or partial hospitalization with a mental health practitioner within 7 days after discharge. Include outpatient visits, intensive outpatient visits, or partial hospitalizations that occur on the date of discharge (see the related "Numerator Inclusions/Exclusions" field).

Evidence Supporting the Measure

Type of Evidence Supporting the Criterion of Quality for the Measure

A clinical practice guideline or other peer-reviewed synthesis of the clinical research evidence

A formal consensus procedure, involving experts in relevant clinical, methodological, public health and organizational sciences

Additional Information Supporting Need for the Measure

- Approximately one in four adults in the United States (U.S.) suffers from mental illness in a given year and nearly half of U.S. adults will develop at least one mental illness in their lifetime (National Alliance on Mental Illness [NAMI], "Mental illness," 2011; Centers for Disease Control and Prevention [CDC], 2011).
- Mental health care costs the health care system $113 billion annually (Garfield & Kaiser Commission on Medicaid and the Uninsured, 2011). Mental health costs increase to $300 billion annually when they include health care and treatment services, lost earnings and wages and disability benefits (Reeves et al., 2011).
- About 3 percent of adults with mental illness receive treatment in inpatient settings, which constitutes the largest share of mental health spending (28 percent) (Levit et al., 2008).
- People with mental illness are at increased risk of suicide, which is the 11th leading cause of death in the U.S., accounting for 30,000 deaths each year (NAMI, "The impact," 2011).
- Mental health is the leading cause of disability in the U.S. Around 45 percent of persons with a mental health disorder suffer from two or more diagnosable disorders (National Institute of Mental Health [NIMH], 2013).
- Mental health is an important aspect of health and well-being. Proper follow-up care can improve health outcomes for adults and children.

Evidence for Additional Information Supporting Need for the Measure

Centers for Disease Control and Prevention. CDC mental illness surveillance. CDC report: mental illness surveillance among adults in the United States. [internet]. Atlanta (GA): Centers for Disease Control and Prevention (CDC); 2011 Sep 1.

Garfield RL, Kaiser Commission on Medicaid and the Uninsured. Mental health financing in the United States: a primer. Washington (DC): The Henry J. Kaiser Family Foundation; 2011 Apr. 46 p.

Levit KR, Kassed CA, Coffey RM, Mark TL, McKusick DR, King E, et al. Projections of national expenditures for mental health services and substance abuse treatment, 2004-2014. Rockville (MD): Substance Abuse and Mental Health Services Administration (SAMHSA); 2008.

National Alliance on Mental Illness (NAMI). Mental illness: what is mental illness: mental illness facts. [internet]. Arlington (VA): National Alliance on Mental Illness (NAMI); 2011 [accessed 2014 Jun 20].

National Alliance on Mental Illness. The impact and cost of mental illness: the case of depression. [internet]. Arlington (VA): National Alliance on Mental Illness; 2011 [accessed 2011 Jun 10].

National Committee for Quality Assurance (NCQA). The state of health care quality 2015. Washington (DC): National Committee for Quality Assurance (NCQA); 2015. 205 p.

National Institute of Mental Health (NIMH). The numbers count: mental disorders in America. [internet]. Bethesda (MD): National Institutes of Health (NIH); 2012 [accessed 2014 Jun 20].

Reeves WC, Strine TW, Pratt LA, Thompson W, Ahluwalia I, Dhingra SS, McKnight-Eily LR, Harrison L, D'Angelo DV, Williams L, Morrow B, Gould D, Safran MA, Centers for Disease Control and Prevention (CDC). Mental illness surveillance among adults in the United States. MMWR Surveill Summ. 2011 Sep 2;60 Suppl 3:1-29. PubMed

Extent of Measure Testing

All HEDIS measures undergo systematic assessment of face validity with review by measurement advisory panels, expert panels, a formal public comment process and approval by the National Committee for Quality Assurance's (NCQA's) Committee on Performance Measurement and Board of Directors. Where applicable, measures also are assessed for construct validity using the Pearson correlation test. All measures undergo formal reliability testing of the performance measure score using beta-binomial statistical analysis.

Evidence for Extent of Measure Testing

Rehm B. (Assistant Vice President, Performance Measurement, National Committee for Quality Assurance, Washington, DC). Personal communication. 2015 Mar 16. 1 p.

State of Use of the Measure

State of Use

Current routine use

Current Use

not defined yet

Application of the Measure in its Current Use

Measurement Setting

Ambulatory/Office-based Care

Behavioral Health Care

Hospital Inpatient

Hospital Outpatient

Managed Care Plans

Transition

Type of Care Coordination

Coordination across provider teams/sites

Professionals Involved in Delivery of Health Services

not defined yet

Least Aggregated Level of Services Delivery Addressed

Single Health Care Delivery or Public Health Organizations

Statement of Acceptable Minimum Sample Size

Unspecified

Target Population Age

Age greater than or equal to 6 years

Target Population Gender

Either male or female

National Strategy for Quality Improvement in Health Care

National Quality Strategy Aim

Better Care

National Quality Strategy Priority

Effective Communication and Care Coordination
Prevention and Treatment of Leading Causes of Mortality

Institute of Medicine (IOM) National Health Care Quality Report Categories

IOM Care Need

Living with Illness

IOM Domain

Effectiveness

Data Collection for the Measure

Case Finding Period

January 1 through December 1 of the measurement year

Denominator Sampling Frame

Enrollees or beneficiaries

Denominator (Index) Event or Characteristic

Clinical Condition

Institutionalization

Patient/Individual (Consumer) Characteristic

Denominator Time Window

not defined yet

Denominator Inclusions/Exclusions

Inclusions
Discharges for members age 6 years and older as of the date of discharge who were hospitalized for treatment of selected mental illness diagnoses and had an acute inpatient discharge with a principal diagnosis of mental illness (Mental Illness Value Set) on or between January 1 and December 1 of the measurement year. To identify acute inpatient discharges:

Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set)
Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set)
Identify the discharge date for the stay

Use only facility claims to identify discharges and diagnoses for denominator events (including readmissions or direct transfers). Do not use professional claims.

To identify readmissions to an acute inpatient care setting:

Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set)
Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set)
Identify the admission date for the stay

Note:

Members must have been continuously enrolled from the date of discharge through 30 days after discharge with no gaps in enrollment.
Acute Readmission or Direct Transfer: If the discharge is followed by readmission or direct transfer to an *acute inpatient care setting* for a principal mental health diagnosis (Mental Health Diagnosis Value Set) within the 30-day follow-up period, count only the last discharge.

Exclusions

Acute Readmission or Direct Transfer: Exclude both the initial discharge and the readmission/direct transfer discharge if the last discharge occurs after December 1 of the measurement year.
Exclude discharges followed by readmission or direct transfer to a nonacute inpatient care setting within the 30-day follow-up period, regardless of principal diagnosis for the readmission. This discharge is excluded from the measure because rehospitalization or transfer may prevent an outpatient follow-up visit from taking place. To identify readmissions to a nonacute inpatient care setting:

Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set)
Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim
Identify the admission date for the stay

Exclude discharges followed by readmission or direct transfer an acute inpatient care setting within the 30-day follow-up period if the principal diagnosis was for non-mental health (any principal diagnosis code other than those included in the Mental Health Diagnosis Value Set). This discharge is excluded from the measure because rehospitalization or transfer may prevent an outpatient follow-up visit from taking place. To identify readmissions to an acute inpatient care setting:

Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set)
Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
Identify the admission date for the stay.

Value Set Information
Measure specifications reference value sets that must be used for HEDIS reporting. A value set is the complete set of codes used to identify the service(s) or condition(s) included in the measure. Refer to the NCQA Web site to purchase HEDIS Volume 2, which includes the Value Set Directory.

Exclusions/Exceptions

not defined yet

Numerator Inclusions/Exclusions

Inclusions
An outpatient visit, intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days after discharge. Include outpatient visits, intensive outpatient visits, or partial hospitalizations that occur on the date of discharge.

Any of the following meet criteria for a follow-up visit:

A visit (FUH Stand Alone Visits Value Set) with a mental health practitioner
A visit (FUH Visits Group 1 Value Set *and* FUH POS Group 1 Value Set) with a mental health practitioner
A visit (FUH Visits Group 2 Value Set *and* FUH POS Group 2 Value Set) with a mental health practitioner
A visit in a behavioral healthcare setting (FUH RevCodes Group 1 Value Set)
A visit in a nonbehavioral healthcare setting (FUH RevCodes Group 2 Value Set) with a mental health practitioner
A visit in a nonbehavioral healthcare setting (FUH RevCodes Group 2 Value Set) with a diagnosis of mental illness (Mental Illness Value Set)
Transitional care management (TCM) services (TCM 7 Day Value Set) where the date of service on the claim is 29 days after the date the member was discharged with a principal diagnosis of mental illness

Note: TCM is a 30-day period that begins on the date of discharge and continues for the next 29 days. The date of service on the claim is 29 days after discharge and not the date of the face-to-face visit.

Exclusions
Unspecified

Value Set Information
Measure specifications reference value sets that must be used for HEDIS reporting. A value set is the complete set of codes used to identify the service(s) or condition(s) included in the measure. Refer to the NCQA Web site to purchase HEDIS Volume 2, which includes the Value Set Directory.

Numerator Search Strategy

Fixed time period or point in time

Data Source

Administrative clinical data

Type of Health State

Does not apply to this measure

Instruments Used and/or Associated with the Measure

Unspecified

Computation of the Measure

Measure Specifies Disaggregation

Does not apply to this measure

Scoring

Rate/Proportion

Interpretation of Score

Desired value is a higher score

Allowance for Patient or Population Factors

not defined yet

Description of Allowance for Patient or Population Factors

This measure requires that separate rates be reported for commercial, Medicaid, and Medicare product lines.

Standard of Comparison

not defined yet

Identifying Information

Original Title

Follow-up after hospitalization for mental illness (FUH): 7-day follow-up.

Measure Collection Name

HEDIS 2016: Health Plan Collection

Measure Set Name

Effectiveness of Care

Measure Subset Name

Behavioral Health

Submitter

National Committee for Quality Assurance - Health Care Accreditation Organization

Developer

National Committee for Quality Assurance - Health Care Accreditation Organization

Funding Source(s)

Unspecified

Composition of the Group that Developed the Measure

National Committee for Quality Assurance's (NCQA's) Measurement Advisory Panels (MAPs) are composed of clinical and research experts with an understanding of quality performance measurement in the particular clinical content areas.

Financial Disclosures/Other Potential Conflicts of Interest

In order to fulfill National Committee for Quality Assurance's (NCQA's) mission and vision of improving health care quality through measurement, transparency and accountability, all participants in NCQA's expert panels are required to disclose potential conflicts of interest prior to their participation. The goal of this Conflict Policy is to ensure that decisions which impact development of NCQA's products and services are made as objectively as possible, without improper bias or influence.

Endorser

National Quality Forum - None

NQF Number

not defined yet

Date of Endorsement

2014 Dec 23

Measure Initiative(s)

Physician Quality Reporting System

Adaptation

This measure was not adapted from another source.

Date of Most Current Version in NQMC

2015 Oct

Measure Maintenance

Unspecified

Date of Next Anticipated Revision

Unspecified

Measure Status

This is the current release of the measure.

This measure updates previous versions:

National Committee for Quality Assurance (NCQA). HEDIS 2015: Healthcare Effectiveness Data and Information Set. Vol. 1, narrative. Washington (DC): National Committee for Quality Assurance (NCQA); 2014. various p.
National Committee for Quality Assurance (NCQA). HEDIS 2015: Healthcare Effectiveness Data and Information Set. Vol. 2, technical specifications for health plans. Washington (DC): National Committee for Quality Assurance (NCQA); 2014. various p.

Measure Availability

Source available for purchase from the National Committee for Quality Measurement (NCQA) Web site .

For more information, contact NCQA at 1100 13th Street, NW, Suite 1000, Washington, DC 20005; Phone: 202-955-3500; Fax: 202-955-3599; Web site: www.ncqa.org .

Companion Documents

The following are available:

National Committee for Quality Assurance (NCQA). The state of health care quality 2015. Washington (DC): National Committee for Quality Assurance (NCQA); 2015 Oct. 205 p.
National Committee for Quality Assurance (NCQA). HEDIS 2016: Healthcare Effectiveness Data and Information Set. Vol. 2, technical update. Washington (DC): National Committee for Quality Assurance (NCQA); 2015 Oct 1. 12 p.

For more information, contact the National Committee for Quality Assurance (NCQA) at 1100 13th Street, NW, Suite 1000, Washington, DC 20005; Phone: 202-955-3500; Fax: 202-955-3599; Web site: www.ncqa.org .

NQMC Status

This NQMC summary was completed by ECRI on June 30, 2003. The information was verified by the measure developer on July 25, 2003.

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Production

Source(s)

National Committee for Quality Assurance (NCQA). HEDIS 2016: Healthcare Effectiveness Data and Information Set. Vol. 1, narrative. Washington (DC): National Committee for Quality Assurance (NCQA); 2015. various p.

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